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Office of Administrative Law Judges
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Issue date: 14May2002

Case No. 2001-BLA-01019

In the Matter of

PAUL PENNINGTON,

Claimant,

v.

RIFLE COAL CO.,

Employer,

and

TRAVELERS INSURANCE CO.,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Respondent.

APPEARANCES[1]:

Cynthia Mulliken, Esq.
Pikeville, Kentucky
For the Claimant

John Logan Griffith, Esq.
Porter, Schmitt, Jones & Banks
Paintsville, Kentucky
For the Employer

BEFORE: DANIEL J. ROKETENETZ
Administrative Law Judge

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[1] The Director, Office of Workers' Compensation Programs, was not represented by counsel at the hearing.

DECISION AND ORDER - AWARD OF BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 (hereinafter referred to as "the Act"), 30 U.S.C. § 901 *et seq.*, and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

On June 18, 2001, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a hearing. (Dir. Ex. 38)[2] A formal hearing in this matter was conducted on February 13, 2002, in Prestonsburg, Kentucky, by the undersigned. All parties were afforded full opportunity to present evidence as provided in the Act and the regulations issued thereunder. The opinion which follows is based on all relevant evidence of record.

ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether the person upon whose disability the claim is based is a miner;

3. Whether the Claimant worked as a miner after December 31, 1969;

4. The length of coal mine employment;

5. Whether the Claimant has pneumoconiosis as defined in the Act and regulations;

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[2] In this Decision and Order, "Dir. Ex." refers to the Director's exhibits, "Er. Ex." refers to the Employer's exhibits, "Cl. Ex." refers to Claimant's exhibits, and "Tr." refers to the transcript of the hearing.

[3] Issues 1, 2, 3, 9, and 10 were withdrawn by counsel for the Employer at the hearing. Additionally, counsel for the Employer and counsel for the Claimant stipulated to 16 years of qualifying coal mine employment.

6. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

7. Whether the Claimant is totally disabled;

8. Whether the Claimant's disability is due to pneumoconiosis;

9. Whether the Claimant has one dependent for the purposes of augmentation;

10. Whether the named Employer is the Responsible Operator;

11. Whether the evidence establishes a change in condition pursuant to §725.309; and,

12. Whether the evidence establishes a change in condition and/or that a mistake in a determination of fact was made in the prior denial pursuant to §725.310[4].

(Dir. Ex. 38)

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

[4] I note that the Employer has contested the issue of modification on the CM-1025 referral sheet. The last denial of the prior claim for benefits was made by an Administrative Law Judge in 1996. The present claim for benefits was filed in 1999, not within the one year period prescribed by §725.310. Therefore, this claim is properly before me as a duplicate claim and will be adjudicated pursuant to the standards of §725.309.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History:

The Claimant, Paul Pennington, filed his first application for benefits on January 1, 1994. (Dir. Ex. 37) That claim was denied by Administrative Law Judge Robert L. Hillyard in a Decision and Order dated January 12, 1996. (Dir. Ex. 37)

The Claimant filed his second application for benefits on September 28, 1998. (Dir. Ex. 1) This claim was denied by the District Director on January 1, 1999, and again on April 1, 1999, after consideration of additional evidence. (Dir. Ex. 9, 10) The Claimant sent a letter to the District Director on March 24, 2000, appealing his April 1, 1999, denial. (Dir. Ex. 15) The District Director elected to treat this appeal as a request for a modification and notified the Claimant of such on March 29, 2000. (Dir. Ex. 15a)

The District Director issued a Proposed Decision and Order denying the request for modification on August 22, 2000. (Dir. Ex. 11) The Claimant filed a modification request of this denial on September 18, 2000. (Dir. Ex. 16) However, after consideration of additional evidence, the District Director again denied benefits on March 14, 2001. (Dir. Ex. 12) The Claimant filed a timely request for a formal hearing and this case was referred to the Office of Administrative Law Judges. (Dir. Exs. 17, 38)

Background:

The Claimant was born on December 28, 1939, and has a third grade education. (Dir. Ex. 1, Tr. 19) He has one dependent for purposes of benefits augmentation, namely his wife, Dena, whom he married on December 24, 1959. (Dir. Ex. 1) In his application for benefits, the Claimant alleges eighteen years of coal mine employment. (Dir. Ex. 1)

At the hearing, the Claimant testified that his entire coal mine employment history was above ground as a heavy equipment operator. (Tr. 12) His various jobs included loading coal, operating a bulldozer, operating a loader, and loading rock and dirt. (Tr. 12) The Claimant stated he began to experience breathing problems in 1991. (Tr. 14) He quit working in the coal mine industry in 1991 after his job was eliminated. (Tr. 14) The Claimant testified that his treating physician is Dr. DeGuzeman who has prescribed oxygen, breathing treatments, pills, and inhalers since he began treating the Claimant in 1991. (Tr. 15) The Claimant also reported that his breathing has gotten worse over the

past year. (Tr. 16) He stated he had a smoking history of one pack per day since the age of fifteen, but that he quit smoking three to four years ago. (Tr. 20)

Applicable Regulations:

Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations.[5]

Length of Coal Mine Employment:

The parties in this matter have stipulated to sixteen years of coal mine employment. Judge Hillyard found sixteen years of qualifying coal mine employment in his previous Decision and Order. (Dir. Ex. 37) This stipulation is supported by the documented evidence of record. Accordingly, I find that the Claimant was a coal miner, as that term is defined in the Act and the Regulations, for a period OF sixteen years. He last worked in the Nation's coal mines in 1991.

Duplicate Claim:

In cases where a Claimant files more than one claim and the earlier claim is denied, the later claim must also be denied on the grounds of the earlier denial unless there has been a material change in condition or the later claim is a request for a modification. Section 725.309(d). The Claimant filed his first claim in 1994. This earlier claim was finally denied by Judge Hillyard in June 1996. The instant claim was filed in September 1998, not within one year of the prior denial, so that it cannot be construed as a modification proceeding pursuant to Section 725.310(a). Therefore, according to Section 725.309(d) this claim must be denied on the basis of the prior denial unless there has been a material change in condition.

The United States Court of Appeals for the Sixth Circuit in the case of Sharondale Corp. v. Ross, 42 F.3d 993 (6th Cir. 1994), adopted the following standard for determining whether a miner had established a material change in condition:

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[5] Amendments to the Part 718 regulations became effective on January 19, 2001. Section 718.2 provides that the provisions of Section 718 shall, to the extent appropriate, be construed together in the adjudication of all claims.

> . . . to assess whether a material change in condition is established, the [administrative law judge] must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then the [administrative law judge] must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

Ross at 997-998.

The Board has further held that a "material change" may only be based upon an element which was previously denied. In Caudill v. Arch of Kentucky, Inc., 22 BLR 1-97 (2000) (en banc on recon.), the Board held that a "material change in conditions" cannot be established based upon an element of entitlement which was not specifically adjudicated against the claimant in prior litigation. Specifically, the original administrative law judge in Caudill concluded that the miner did not suffer from coal workers' pneumoconiosis, but he did not conclude whether the miner had a totally disabling respiratory or pulmonary impairment. As a result, the Board held that the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions . . . ." Id. The "material change" standard "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Id. The Board further stated that, unless an element has been previously adjudicated against the claimant, "new evidence cannot establish that the miner's condition has changed with respect to that element." Id.

The present claim arises in the Sixth Circuit.[6] Therefore, applying the Sharondale standard, herein, the evidence submitted subsequent to the date of the prior denial will be reviewed, to determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. If he is successful in

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[6] The Benefits Review Board has held that the law of the circuit in which the Claimant's last coal mine employment occurred is controlling. Shupe v. Director, OWCP, 12 BLR-200 (1989) The Claimant's last coal mine employment took place in Kentucky, which falls under the Sixth Circuit's jurisdiction.

establishing a material change, then all of the record evidence must be reviewed to determine whether he is entitled to benefits.

The previous claim was denied when it was determined that the Claimant did not establish the existence of pneumoconiosis. Accordingly, the newly submitted medical evidence will be reviewed in order to determine whether there has been a material change in condition. It should be noted that medical evidence, dating prior to the last denial of benefits in 1996, has been submitted. (Dir. Ex. 37) These records cannot assist in the determination of a material change in condition, and accordingly, will not be addressed unless a material change is found.

Determination of Pneumoconiosis:

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to Section 718.202, the Claimant can demonstrate pneumoconiosis by means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in Sections 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under Section 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with Section 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis.

At the outset, I note that in a 1999 medical report discussed in detail below, Dr. DeGuzman stated that he reviewed an x-ray which demonstrated moderate to severe interstitial pulmonary fibrosis on both sides and nodular densities in all pulmonary zones on both sides. (Dir. Ex. 28) Based upon “International Label Organization Classification, I”, Dr. DeGuzman notes, “I would say that this is compatible to black lung or silicosis or pulmonary pneumoconiosis 2/1 and probably q.” I note that Dr. DeGuzman states the x-ray he reviewed was taken at Paul B. Hall Medical Center but does not record the date of the film or if it was reviewed by any other physician. I have reviewed the record closely and have found no x-rays taken since the prior denial by Judge Hillyard specifically labeled as performed at Paul B. Hall

Medical Center. Furthermore, I note that, of the new x-ray evidence of record, no other reader marked a film with a 2/1 profusion. The record evidence previously considered by Judge Hillyard contains a number of reports authored by Dr. DeGuzman. In at least one of those older narratives, Dr. DeGuzman refers to a May 31, 1995, x-ray performed at Paul B. Hall Medical Center. Upon review of that film, Dr. DeGuzman records findings nearly identical to those expressed in his 1999 medical report, including a finding of a 2/1 profusion and probable q size small opacities. In light of the above, I am unable to determine definitively what film Dr. DeGuzman was referring to in his 1999 report and whether that film was taken prior to the last denial by Judge Hillyard. A material change in condition may only be established upon review of evidence generated since the prior denial. Due to the significant question regarding when the x-ray described in the 1999 report of Dr. DeGuzman was actually taken, I am unable to assign his interpretation of this film any weight in assessing the new medical evidence of record.

The medical evidence of record clearly obtained since the prior denial by Judge Hillyard contains 15 readings of six x-rays. These films have been reviewed by eleven different physicians.

An October 15, 1998, film was found to be negative for pneumoconiosis by B-readers[7] and board-certified radiologists, Drs. Barrett and Sargent. (Dir. Ex. 8) B-reader Dr. Westerfield found this film to be positive for pneumoconiosis with a 1/0 profusion. (Dir. Ex. 28)

Dr. Sargent interpreted a February 22, 1999, x-ray as negative for pneumoconiosis. (Dir. Ex. 30) Additionally, Dr. Sargent noted a "widened aorta" on the narrative comment section of his report. B-reader Dr. Sundaram and A-reader Dr. Potter read this film as positive for pneumoconiosis, each finding a 1/1 profusion (Dir.

[7] A "B-reader" is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United states Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because "B-readers" are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of other physicians. Taylor v. Director, OWCP, 9 BLR 1-22 (1986).

Exs. 26, 27)

A July 26, 1999, film was found to be positive by B-reader and board-certified radiologist, Dr. Patel with a 1/0 profusion. (Dir. Ex. 28) Dr. Sargent interpreted this film as negative. (Dir. Exs. 31, 32) He also recorded a finding of a "widened tortuous aorta" and "sub-pleural fat shadows." Dr. Sargent also questioned whether the Claimant had a smoking history.

Dr. Brandon, a B-reader and board-certified radiologist, read an August 28, 2000, film as positive for pneumoconiosis with a 2/2 profusion. (Dir. Ex. 35)

A June 27, 2001, film was interpreted as negative by Dr. Barrett and by B-reader and board-certified physicians, Drs. Scott and Wheeler. (Dir. Exs. 39, Er. Ex. 3) Drs. Potter and Sundaram found this film to be positive for pneumoconiosis with a ½ and 2/2 profusion, respectively. (Dir. Ex. 39)

B-reader and board-certified radiologist, Dr. Jarboe, found an August 14, 2001, film to be negative for pneumoconiosis. (Er. Ex. 1)

Upon careful review of the x-ray evidence of record, I find that the preponderance of negative readings by B-readers and board-certified physicians substantially outweighs the positive x-ray interpretations of record. Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. Dixon v. North Camp Coal Co., 8 BLR 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers qualifications. Goss v. Eastern Associated Coal Co., 7 BLR 1-400 (1984). Accordingly, greater weight may be assigned to an x-ray interpretation of a B-reader. Aimone v. Morrison Knudson Co., 8 BLR 1-32 (1985).

In the instant case, eight negative readings were rendered by five physicians who are both B-readers and board-certified radiologists. In contrast, only two positive findings were made by physicians equally as credentialed. Of the remaining positive interpretations, three were rendered by physicians who are B-readers only and two were rendered by an A-reader. The Board has held that it is proper to credit the interpretation of a dually qualified physician, i.e. one who is both a B-reader and board-certified radiologist, over the interpretation of a B-reader.

Cranor v. Peabody Coal Co., 22 BLR 1-1 (1999) (en banc on recon.); Sheckler v. Clinchfield Coal Co., 7 BLR 1-128 (1984). See also Roberts v. Bethlehem Mines Corp., 8 BLR 1-211 (1985). Accordingly, I find the opinions of Drs. Sargent, Barrett, Scott, Wheeler, and Jarboe entitled to more weight than the opinions of Drs. Westerfield, Sundaram, and Potter.

The record also contains more negative interpretations than positive. It is within the discretion of the administrative law judge to defer to the numerical superiority of the x-ray interpretations. Edmiston v. F & R Coal Co., 14 BLR 1-65 (1990). The United States Court of Appeals for the Sixth Circuit, under whose appellate jurisdiction this case arises, has confirmed that consideration of the numerical superiority of the x-ray interpretations, when examined in conjunction with the readers' qualifications, is a proper method of weighing x-ray evidence. Stanton v. Norfolk & Western Railway Co., 65 F.3d 55 (6th Cir. 1995) (citing Woodward v. Director, OWCP, 991 F.2d 314 (6th Cir. 1993). Accordingly, I find that the more numerous negative interpretations of Drs. Sargent, Barrett, Scott, Wheeler, and Jarboe outweigh the positive interpretations rendered by equally qualified physicians Drs. Patel and Brandon. Consequently, I find that the preponderance of the x-ray evidence, as reviewed by several B-readers and board-certified radiologists, fails to establish the existence of pneumoconiosis under Section 718.202(a)(1).

Pursuant to Section 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

Section 718.202(a)(3) provides that it shall be presumed that the miner was suffering from pneumoconiosis if the presumptions described in Sections 718.304, 718.305 or 718.306 are applicable. Section 718.304 is not applicable because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

The fourth and final way to establish the existence of pneumoconiosis is set forth in Section 718.202(a)(4). This subsection provides for such a finding where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the

physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. Upon review of the medical opinion evidence, I find that the better-reasoned and better-documented reports of record establish that pneumoconiosis is present.

The Claimant was examined by board-certified Internal Medicine and Pulmonary Disease specialist, Dr. Westerfield on October 15, 1998. (Dir. Ex. 28) Dr. Westerfield recorded an occupational history of eighteen years of coal mine employment and a social history which included a smoking history of one pack per day since the age of eight and continuing until June of 1998. A medical history was also taken. The Claimant's chief complaint during this visit was shortness of breath with limited activity. Dr. Westerfield performed a physical examination, chest x-ray, arterial blood gas analysis, and pulmonary function study. Upon review of the spirometry, Dr. Westerfield noted it demonstrated a severe obstructive ventilatory dysfunction. There was also marked improvement in flow rates following administration of inhaled bronchodilaters. The arterial blood gas revealed moderate oxygen desaturation on room air at rest and there was no significant change in the arterial blood gas with exercise. Dr. Westerfield made a final diagnosis of 1.) coal workers' pneumoconiosis, category 1; and 2.) COPD. The etiology of these illnesses was 1.) Inhalation of coal dust; 2.) Cigarette smoking; and 3.) Asthma. An impairment rating of 50 percent was found based upon the American Medical Association (hereinafter "AMA") Class III analysis. Dr. Westerfield attributed this impairment entirely to the Claimant's COPD.

On a Department of Labor follow-up questionnaire form also dated October 15, 1998, Dr. Westerfield checked yes in response to the question "Does the Miner have an occupational lung disease caused by coal mine employment." (Dir. Ex. 28) He also indicates that the Claimant has a totally disabling pulmonary impairment, that the etiology of this pulmonary disability is COPD, and that the Claimant does not have the respiratory capacity to perform his last coal mine employment.

The record also contains a March 1, 1999, letter from Dr. Westerfield to the Department of Labor in which Dr. Westerfield responds to additional questions posed by a Department claims examiner. (Dir. Ex. 25) In this letter, Dr. Westerfield states that the Claimant's respiratory impairment is due to COPD and that the Claimant has a chronic lung disease due to cigarette smoking. This opinion is based upon the 50 pack-year smoking history

reported by the Claimant and the spirometry results which were representative of emphysema and chronic bronchitis. Dr. Westerfield again states that the Claimant is totally disabled due to COPD and cannot perform his last coal mine employment or similar arduous manual labor.

The Claimant was examined by Dr. DeGuzman sometime in 1999[8]. (Dir. Ex. 28) A surface mining history of eighteen years was recorded. Dr. DeGuzman noted that he had been treating the Claimant since 1991 and sees the Claimant approximately once a month for care of his breathing problems. On this visit, Dr. DeGuzman performed a physical examination, reviewed a chest x-ray, and considered the results of a pulmonary function study[9]. As noted above, Dr. DeGuzman found category 2/1 pneumoconiosis with size "q" small opacities based upon the chest x-ray. Upon physical examination, he reported "symmetrical sluggish and breathing in expansion", "diminished breath sounds transmissions and expansion", and "ronchi (sic) on both lungs." Dr. DeGuzman noted that pursuant to the "AMA Guide, Physician's Guide to Pulmonary Impairment, considering this class 4 and probably 35% and [the results of] his pulmonary function tests dated May 18, 1999 in my office" that the Claimant had a severe obstructive pulmonary airway and increased pulmonary resistence. Dr. DeGuzman also opined that the Claimant was incapable of performing coal mine work or any other kind of job that requires physical or mental exertion, exposure to hot or cold temperature environments, or exposure to chemical gas, smoke, or dust filled environments.

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[8] Dr. DeGuzman's report is undated. The report is included in Director's Exhibit 28 which is prefaced by a cover letter from the Claimant dated April 4, 2000. Dr. DeGuzman records in his report that the Claimant's date of birth is December 28, 1939, and that he was 59 at the time of the examination. Dr. DeGuzman also discusses his review of a May 18, 1999, spirometry report. From this data, it can be extrapolated that the examination occurred sometime in 1999. Therefore, the report of the physical examination is medical evidence submitted since the prior denial of benefits and may be considered in this subsequent claim. However, for the reasons discussed above, this is not evidence of when the chest x-ray discussed in his report was taken.

[9] The results of the May 18, 1999, spirometry are recorded in the body of Dr. DeGuzman's report.

The Claimant was examined by Dr. Rasmussen, a board-certified internal medicine specialist, on July 26, 1999. (Dir. Ex. 28) Dr. Rasmussen recorded a medical history, a thirteen year occupational history as a heavy equipment operator in the coal mine industry and a smoking history of one pack per day from age fifteen (1954) until 1998. A physical examination, chest x-ray, spirometry, arterial blood gas analysis, and EKG were performed. On examination, Dr. Rasmussen noted diminished chest expansion, moderately to markedly reduced breath sounds, persistent right lower lobe rales, and prolonged expiratory phases with forced respirations. He recorded the chest x-ray as being 1/0, based on the interpretation by B-reader and board-certified radiologist Dr. Patel. The pulmonary function study demonstrated a severe slightly reversible obstructive insufficiency and markedly reduced breathing capacity. The arterial blood gas analysis revealed a minimal resting hypoxemia. These two results in combination were indicative of a moderately severe loss of respiratory function as reflected by the significant degree of ventilatory impairment. Dr. Rasmussen opined that this impairment rendered the Claimant totally disabled from his last coal mine employment or from similar arduous labor. Dr. Rasmussen also stated that the Claimant had a significant history of coal mine dust exposure and the changes in his x-ray were consistent with pneumoconiosis. It was medically reasonable to conclude that the coal workers' pneumoconiosis had arisen from his coal mine employment. There were also three risks factors noted by Dr. Rasmussen for the Claimant's impairment function: 1.) Cigarette smoking; 2.) Possible asthma; and 3.) Coal mine dust exposure. The latter, Dr. Rasmussen opined, "must be considered a contributing factor to his disabling respiratory insufficiency."

The record contains an August 22, 2000, consultative report by board-certified Internal Medicine and Pulmonary Disease specialist, Dr. Burki. (Dir. Ex. 33) Dr. Burki's report is in the form of a response letter to a Department of Labor claims examiner and does not contain a detailed list of the medical data he reviewed. However, it is clear from the body of the report that Dr. Burki examined several x-ray reports. The record also contains two other consultative reports authored by Dr. Burki in which he invalidated a July 26, 1999, pulmonary function study and validated an October 15, 1998, spirometry. Therefore, I find that Dr. Burki's opinion is credible and reliable because he reviewed a variety of medical evidence. Dr. Burki states that the Claimant has pneumoconiosis. However, he notes that "given the minimal evidence of pneumoconiosis on radiographs (Drs. Sargent and Barrett have read the films as negative, other readers have classified them as 1/0 or 1/1) the likely contribution of coal dust exposure to the pulmonary functional abnormality, while possible, is likely to be minimal." Dr. Burki also opined that the Claimant suffers from a pulmonary

impairment which would prevent his last coal mine employment or similar arduous manual labor based upon the values of the spirometry and arterial blood gas analysis both performed on October 15, 1998. The etiology of this impairment, Dr. Burki concludes, is due primarily to cigarette smoking.

Dr. Sundaram, a board-certified Internal Medicine specialist, examined the Claimant on July 10, 2001. (Dir. Ex. 39) In his report dated July 10, 2001, Dr. Sundaram states that he is the Claimant's treating physician. He records a twenty-year coal mine employment history and notes that the Claimant has quit smoking. A physical examination, and pulmonary function study were performed. Upon examination, Dr. Sundaram recorded bilateral rhonchi and wheezes. He reviewed a chest x-ray dated June 27, 2001, and found it positive for pneumoconiosis with a 2/2 profusion. The pulmonary function study results were indicative of severe obstruction as well as low vital capacity, possibly from a concomitant restrictive defect. Dr. Sundaram's final diagnosis was 1.) Coal workers' pneumoconiosis; and 2.) COPD. He further stated that the Claimant "is considered totally disabled due to his breathing impairment caused in part by the exposure to coal dust."

The Claimant was examined by Dr. Broudy on August 14, 2001. (Er. Ex. 1) Dr. Broudy is a board-certified Internal Medicine and Pulmonary Disease specialist. In addition to taking occupational, social, and medical histories from the Claimant, Dr. Broudy performed a chest x-ray, spirometry, and arterial blood gas analysis. An eighteen-year surface mining career as a heavy equipment operator and a pack-per-day smoking habit from age 15 until 3 years ago were recorded. On physical examination, Dr. Broudy noted that respirations were normal but chest expansion was diminished. Lungs were hyperresonant to percussion and there was markedly diminished aeration. Inspiratory and especially expiratory wheezes with markedly expiratory delay throughout when auscultating the lungs was also recorded. The chest x-ray was classified as category 0. The pulmonary function study revealed a severe obstruction with mild improvement after bronchodilation. The Claimant's effort during this test was satisfactory. The arterial blood gas analysis was demonstrative of moderate hypoxemia. Based upon the examination, histories, and test results, Dr. Broudy diagnosed 1.) Severe COPD with mild responsiveness to bronchodilators; 2.) Obesity; and 3.) Gastroesophageal reflux. He opined that the Claimant did not have coal workers' pneumoconiosis. Because of the Claimant's COPD, the Claimant did not retain the respiratory capacity to perform the work of an underground coal miner or similar arduous manual labor. The Claimant's COPD was the result of cigarette smoking and perhaps

some predisposition to asthma or bronchospasms. Dr. Broudy stated he did not believe the Claimant had any significant pulmonary or respiratory impairment that had arisen from the Claimant's occupation as a coal miner.

The record also contains a supplemental report authored by Dr. Broudy and dated September 24, 2001. (Er. Ex. 2) Dr. Broudy states that he has reviewed the report of and test results conducted by Dr. Sundaram. On review of the July 10, 2001, spirometry, Dr. Broudy opined that the

> tracings . . . suggest that exhalation was not as forceful as it should be. I believe sub-optimal effort accounts for the results that are lower then what was obtained by me . . . on August 14, 2001. Technically, the results may be valid, however, because there is repeatability between the test trials.

The additional information provided to him did not change Dr. Broudy's opinion regarding the existence of pneumoconiosis or the causation of the Claimant's respiratory impairment.

Reviewing the medical narrative evidence of record submitted since the prior denial of benefits by Judge Hillyard, I find that pneumoconiosis has been established pursuant to §718.202(a)(4). In doing so, I rely on the medical opinions of Drs. Westerfield, Rasmussen, DeGuzman, Sundaram, and Burki. I find their opinions to be well-reasoned, well-documented, and based upon the objective laboratory data of record. Four of these five physicians are highly qualified with Drs. Burki and Westerfield each being board-certified in Internal Medicine and Pulmonary Disease and Drs. Rasmussen and Sundaram being board-certified in Internal Medicine. While Dr. Broudy is also a highly-credentialed physician, whose opinion is also based upon physical examination and test results, I find his opinion outweighed by the other physicians of record.

Drs. Rasmussen and Westerfield each had the opportunity to personally examine the Claimant as well as conduct numerous medical tests. Dr. DeGuzman and Dr. Sundaram each serve as the Claimant's treating physician. As such, they had the benefit of examining the Claimant on several occasions and of conducting and reviewing multiple test results. More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. Onderko v. Director, OWCP, 14 BLR 1-2 (1989). While the opinion of a treating physician may be accorded greater weight, a judge is not required to accord greater weight to

the opinion of a physician "based solely on his status as Claimant's treating physician. Rather, this is one factor which may be taken into consideration." Tedesco v. Director, OWCP, 18 BLR 1-103 (1994) Other factors include whether the report is well-reasoned and well-documented. See Peabody Coal Co. v. Groves, ___ F.3d ___, Case No. 00-3867 (6th Cir. Jan. 17, 2002); McClendon v. Drummond Coal Co., 12 BLR 2-108 (11th Cir. 1988). I find the reports of Drs. DeGuzman and Sundaram meet this criteria.

As the existence of pneumoconiosis has been established pursuant to §718.202(a)(4), the Claimant has established, as a matter of law, a material change in condition pursuant to §725.309. Therefore, all of the evidence of record will now be examined to determine if the Claimant is entitled to benefits.

In addition to the x-ray evidence discussed in detail above, the record contains thirteen reports of four x-rays as interpreted by ten physicians. (Dir. Ex. 37) A September 3, 1991, film was found to be positive by Drs. Anderson, Westerfield, and Penman. (Dir Ex. 37) Dr. Anderson recorded a 1/1 profusion, Dr. Westerfield recorded a 1/0 profusion, and Dr. Penman recorded a ½ profusion.

A December 19, 1991, lumbar spine x-ray series was reviewed by orthopedic specialists, Drs. Sheriden and Sharer. (Dir. Ex. 37) As this film is of the spinal area, it is of little assistance herein.

Drs. Spitz, Shipley, Wiot, Halbert, and Sargent all interpreted a February 2, 1994, x-ray as negative for pneumoconiosis. (Dir. Ex. 37) Each of these physicians are B-readers and board-certified radiologists.

A December 19, 1994, film was found to be negative by Drs. Spitz, Wiot, Broudy, and Shipley. Dr. Broudy is a B-reader.

Considering the x-ray evidence submitted in the prior claim for benefits in conjunction with the x-ray interpretations submitted in this duplicate claim, I assign less weight to the older interpretations of record. Greater probative weight may be assigned to the most recent x-ray evidence, given the progressive nature of black lung disease. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149 (1989) (en banc); Stanford v. Director, OWCP, 7 BLR 1-541 (1984). As discussed above, I find that the x-ray interpretations submitted since the prior denial by Judge Hillyard fail to establish pneumoconiosis. Even when this x-ray evidence is considered in conjunction with the older radiographs of record, the vast majority of interpretations by the dually qualified readers were negative for the disease. Consequently, I find that the

preponderance of the x-ray evidence, as reviewed by several B-readers and board-certified radiologists, fails to establish the existence of pneumoconiosis under Section 718.202(a)(1).

Pneumoconiosis may not be established pursuant to Section 718.202(a)(2), as the record contains no biopsy or autopsy evidence. Likewise pneumoconiosis may not be demonstrated by one of the presumptions listed in Sections 718.304, 718.305 or 718.306. Section 718.304 is not applicable because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, Section 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

The fourth and final way to establish the existence of pneumoconiosis is set forth in Section 718.202(a)(4). This subsection provides for such a finding where a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis. Any such finding shall be based upon objective medical evidence and shall be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. Upon review of the medical opinion evidence, I find that the better-reasoned and better-documented reports of record establish that pneumoconiosis was present.

Dr. DeGuzman examined the Claimant on November 16, 1991. (Dir. Ex. 37) An eighteen-year above-ground coal mine employment history and a smoking history of one pack per day for thirty-four years and continuing were recorded. Dr. DeGuzman examined the Claimant and made a diagnosis of COPD, coal workers' pneumoconiosis, and chronic arthritis of the right shoulder and lumbar spine.

The record contains reports by orthopaedic specialists, Drs. Shafer and Sheridan, dated December 16, 1991, and December 17, 1991, respectively. (Dir. Ex. 37) Both reports relate to the diagnosis, care, and treatment of the Claimant's back and shoulder condition. (Dir. Ex. 37) The record also contains a number of laboratory reports from National Health Laboratories in Louisville, Kentucky dated March 30, 1992. (Dir. Ex. 37) None of the tests performed are of a type which would assist me in assessing pneumoconiosis or total disability stemming from pneumoconiosis. Neither the reports of Drs. Shafer or Sheridan nor the laboratory

reports from National Health Laboratories are of assistance herein in determining eligibility for benefits and will not be recounted.

In a June 29, 1992, report, Dr. DeGuzman placed the Claimant on lifting, walking, and carrying restrictions. (Dir. Ex. 37) The medical conditions necessitating these restrictions included arthritis of the right shoulder, carpal tunnel syndrome, chronic lumbar arthritis, COPD, and coal workers' pneumoconiosis. History and physical are the two criteria Dr. DeGuzman lists as the basis for his conclusions.

The Claimant was examined by Dr. Fritzhand on February 2, 1994. (Dir. Ex. 37) Dr. Fritzhand recorded an occupational history of eighteen years of coal mine employment as a heavy equipment operator and a smoking history of one pack per day since 1957 and continuing. A physical examination, chest x-ray, spirometry, EKG, and an arterial blood gas analysis were performed. On physical examination, Dr. Fritzhand noted an increased A/P diameter of the chest, decreased diaphragmatic excursion and chest expansion, markedly distant breath sounds, and distant expiratory wheezes. Dr. Fritzhand also recorded that the Claimant did not use his accessory muscles of respiration and that no rales or rhonchi were heard. The chest x-ray was found to be negative for pneumoconiosis. Dr. Fritzhand noted that the pulmonary function study was "reasonably normal", but that the FEV1 value was invalid. On the laboratory report of the spirometry, Dr. Fritzhand wrote "inhalation of effort was poor to fair." A cardiopulmonary diagnosis of COPD due to cigarette smoking was made by Dr. Fritzhand. He also noted that the Claimant's pulmonary impairment would prevent his last coal mine employment.

Dr. DeGuzman examined the Claimant on February 3, 1994. (Dir. Ex. 37) Eighteen years coal mine employment was noted. Dr. DeGuzman also records that he had examined the Claimant approximately two years earlier then complaining of smothering, productive cough, easy fatigue, and dizzy spells. On physical examination, Dr. DeGuzman noted diminished expansion and breath sound transmission, occasional rhonchi on both lungs, but no rales. The final diagnosis included 1.) COPD; and 2.) Coal workers' pneumoconiosis.

The Claimant was again seen by Dr. DeGuzman on March 3, 1994. (Dir. Ex. 37) The Claimant's chief complaints were shoulder, back, and arm pain. The final diagnosis included 1.) Acute arthritis, right shoulder; 2.) Chronic lumbar arthritis; 3.) Carpal tunnel syndrome, right; 4.) COPD; and 5.) Coal workers' pneumoconiosis.

The Claimant was examined by Dr. Broudy on December 19, 1994.

(Dir. Ex. 37) A smoking history of one pack per day since the age of nineteen and an above-ground coal mine employment history of eighteen years was recorded. In addition to taking occupational, social, and medical histories, Dr. Broudy performed a physical examination, chest x-ray, spirometry, and arterial blood gas analysis. On examination, Dr. Broudy noted diminished chest expansion, decreased aeration of the lungs and expiratory delay with wheezes on forced expiration. The patient's effort did not appear maximal. Dr. Broudy reviewed the chest x-ray and classified it as Category 0 based upon the UCC-ILO classification system. The pulmonary function study showed evidence of obstruction, but the patient's effort was not maximal. The overall results, however, still exceeded the minimum federal criteria for disability. The arterial blood gas analysis revealed moderate hypoxemia with elevation of the carboxyhemoglobin indicating continued exposure to smoke. Dr. Broudy's final diagnosis was chronic bronchitis with moderate chronic airways obstruction. He opined the Claimant did not have pneumoconiosis and that he retained the respiratory capacity to perform his last coal mine employment or similar arduous manual labor. The Claimant's chronic bronchitis was the result of cigarette smoking.

Dr. DeGuzman again examined the Claimant sometime in 1995. (Dir. Ex. 37) Once again, Dr. DeGuzman did not date his report. Attached to the report is a cover letter written by the Claimant's former counsel and dated June 2, 1995. The Claimant's date of birth is recorded in the report as December 28, 1939, and he is listed as fifty-four years old at the time of the examination. Dr. DeGuzman also makes reference to a January 5, 1995, pulmonary function study and a May 31, 1995, x-ray in the report. Based on this data, it can be extrapolated that the examination occurred sometime in 1995. On this visit, Dr. DeGuzman noted the Claimant's pertinent medical, social and occupational history, performed a physical examination and reviewed a January 5, 1995, spirometry and a March 31, 1995, chest x-ray. The physical examination revealed diminished expansion and breath sounds transmission. Rhonchi were heard on both lungs. Based upon the pulmonary function study, Dr. DeGuzman concluded that the Claimant had a severe obstructive pulmonary airway and increased pulmonary resistence. He interpreted the chest x-ray as category 2/1 and probably "q". Using the AMA Guide, Physician's Guide to Evaluating Permanent Impairment and considering the Claimant's level of impairment as Class III and almost reaching Class IV, Dr. DeGuzman opined the Claimant's overall impairment was 35 to 45 percent. The Claimant could not return to coal mine employment or other similar work.

The record also contains a January 5, 1999, follow-up report authored by Dr. DeGuzman. On physical examination Dr. DeGuzman

noted rales in both lungs and rhonchi heard most on the right lung field. His diagnosis included 1.) COPD; 2.) Coal workers' pneumoconiosis; and 3.) Chronic lumbar arthritis.

Considering the old medical narrative evidence of record with the medical reports submitted since the prior denial by Judge Hillyard, I find that pneumoconiosis has been established pursuant to §718.202(a)(4). In doing so, I rely primarily on the more recent medical evidence as pneumoconiosis is a latent and progressive disease. A medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. Gillespie v. Badger Coal Co., 7 BLR 1-839 (1985). See also Bates v. Director, OWCP, 7 BLR 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight years earlier); Kendrick v. Kentland-Elkhorn Coal Co., 5 BLR 1-730 (1983); Cranor v. Peabody Coal Co., 22 BLR 1-1 (Oct. 29, 1999) (en banc on recon.); Woodward v. Director, OWCP, 991 F.2d 314 (6th Cir. 1993); Mullins Coal Co. of Virginia v. Director, OWCP, 483 U.S. 135 (1987), *reh'g. denied*, 484 U.S. 1047 (1988). In Crace v. Kentland-Elkhorn Coal Corp., 109 F.3d 1163 (6th Cir. 1997), the court held that the denial of benefits by an administrative law judge was supported by substantial evidence in the record. "Recent evidence is particularly important in black lung cases, where because of the progressive nature of pneumoconiosis, more recent evidence is often accorded more weight." Id.

Of the seven physicians of record who examined the Claimant directly or authored a consultative report, or both, five determined that the Claimant suffers from pneumoconiosis. The five physicians diagnosing pneumoconiosis were Drs. Burki, DeGuzman, Westerfield, Rasmussen, and Sundaram. I assign the opinions of these five physicians probative weight on this issue as I find their opinions to be well-reasoned and well-documented. Drs. Westerfield, DeGuzman, Rasmussen, and Sundaram each had the opportunity to examine the Claimant on at least one occasion. Drs. Sundaram, Rasmussen, Burki, and Westerfield are all highly credentialed physicians, each being board-certified in Internal Medicine. Drs. Burki and Westerfield also have board-certifications in Pulmonary Disease.

Drs. DeGuzman and Sundaram serve as the Claimant's treating physicians and, as such, I find their opinions to be highly probative. More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. Onderko v. Director, OWCP, 14 BLR 1-2 (1989). While

the opinion of a treating physician may be accorded greater weight, a judge is not required to accord greater weight to the opinion of a physician "based solely on his status as Claimant's treating physician. Rather, this is one factor which may be taken into consideration." Tedesco v. Director, OWCP, 18 BLR 1-103 (1994) Other factors include whether the report is well-reasoned and well-documented. See Peabody Coal Co. v. Groves, ___ F.3d ___, Case No. 00-3867 (6th Cir. Jan. 17, 2002) McClendon v. Drummond Coal Co., 12 BLR 2-108 (11th Cir. 1988). I find the opinions of Drs. DeGuzman and Sundaram to be well-reasoned and documented. Each took and considered complete and accurate medical, social, and occupational histories in making their assessments. Each reviewed objective laboratory data. The record reflects that Dr. DeGuzman personally examined the Claimant on numerous occasions dating back to 1991.

As stated above, I have found the radiographic evidence of record to be negative for pneumoconiosis. While some of the physicians of record who found pneumoconiosis based their diagnosis, in part, upon a positive chest x-ray interpretation I note that no physician of record based their entire opinion solely upon a positive radiograph. As such, I find their opinions credible and reliable. It is error to discredit a physician's report solely because of his or her reliance upon non-qualifying testing where the physician also relied upon a physical examination, work and medical histories, and symptomatology of the miner. Baize v. Director, OWCP, 6 BLR 1-730 (1984); Wike v. Bethlehem Mines Corp., 7 BLR 1-593 (1984); Coen v. Director, OWCP, 7 BLR 1-30 (1984); Sabett v. Director, OWCP, 7 BLR 1-299 (1984). See also Cornett v. Benham Coal, Inc., 227 F.3d 569 (6th Cir. 2000).

Drs. Broudy and Fritzhand determined that the Claimant does not suffer from pneumoconiosis. I assign less weight to the opinion of Dr. Fritzhand, given the age of his medical opinion. I also find his opinion outweighed by the well-documented and well-reasoned positive opinions of record rendered by highly qualified physicians. While I find the reports of Dr. Broudy to be credible on this issue, I find that his findings are simply outweighed by the sheer volume of equally reliable, reasoned, documented, and credible medical reports to the contrary.

Furthermore, considering the medical narrative evidence in conjunction with the x-ray evidence of record, I find that pneumoconiosis is established. Radiographs are but one method for determining the existence of pneumoconiosis. The five physicians of record based their overall opinion on extensive data including x-rays, occupational, social, and medical histories,

symptomatology, physical examinations, and other objective testing. In many cases of record, the physicians who interpreted the x-ray never personally examined the Claimant or reviewed any other information or testing relating to his medical condition. It is proper to assign more weight to the opinions of physicians who considered extensive medical data over those who considered less information. See Church v. Eastern Assoc. Coal Corp., 20 BLR 1-8 (1996). Additionally, the Board has held that an administrative law judge may accord less weight to a consulting or non-examining physician's opinion on grounds that he or she does not have first-hand knowledge of the miner's condition. See Bogan v. Consolidation Coal Co., 6 BLR 1-1000 (1984). See also Cole v. East Kentucky Collieries, 20 BLR 1-51 (1996) (the administrative law judge acted within his discretion in according less weight to the opinions of the non-examining physicians; he gave their opinions less weight, but did not completely discredit them). Reviewing the evidence in its entirety, I find that the Claimant has established the existence of pneumoconiosis.

Arising Out of Coal Mine Employment:

Next, the Claimant must establish that his pneumoconiosis arose, at least in part out of coal mine employment. See §718.203(a) It is presumed that pneumoconiosis of a Claimant who establishes ten or more years of coal mine employment arose out of coal mine employment. Id. As the Employer in this case stipulated to coal mine employment of sixteen years, and no evidence to the contrary has been offered, I find that the Claimant's pneumoconiosis arose out of coal mine employment.

Total Disability:

While the Claimant has established the existence of pneumoconiosis arising out of coal mine employment, the Claimant must also establish he is totally disabled before benefits may be awarded. Total disability is defined as the miner's inability, due to a pulmonary or respiratory impairment, to perform his or her ususal coal mine work or engage in comparable gainful work in the immediate area of the miner's residence. § 718.204(b)(1)(i) and (ii). Total disability can be established pursuant to one of the four standards in Section 718.204(b)(2) or the irrebuttable presumption of Section 718.304, which is incorporated into Section 718.204(b)(1). The presumption is not invoked here because there is no x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, a miner shall be considered totally disabled if he meets the criteria set forth in

Section 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under Section 718.204(c), the precursor to §718.204(b)(2), that all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. Shedlock v. Bethlehem Mines Corp., 9 BLR 1-195, 1-198 (1986); Rafferty v. Jones & Laughlin Steel Corp., 9 BLR 1-231, 1-232 (1987). Furthermore, the Claimant must establish this element by a preponderance of the evidence. Gee v. W.G. Moore & Sons, 9 BLR 1-4, 1-6 (1986).

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where a pulmonary function test demonstrates FEV1[10] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[11] or MVV[12] values equal to or less than the applicable table values. Alternatively, a qualifying FEV1 reading together with an FEV1/FVC ratio of 55 percent or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. §718.204(b)(2)(i) and Appendix B. Assessment of these results is dependent on the Claimant's height which was recorded as 67, 68, and 67 inches. Considering this discrepancy, I find the Claimant's height to be 68 inches for the purposes of evaluating the pulmonary function studies. Protopappas v. Director, OWCP, 6 BLR 1-221 (1983).

The record contains the results of eight pulmonary function studies. (Dir. Exs. 28, 37, 39) A test dated February 2, 1994, produced a qualifying FEV1 after bronchodialation and a qualifying MVV pre-bronchodiolation. (Dir. Ex. 37) Dr. Fritzhand, who observed the test, stated in his accompanying report that the FEV1 values were invalid. A December 19, 1994, spirometry failed to produce qualifying values under the Regulations. (Dir. Ex. 37)

A pulmonary function study performed on January 5, 1995, produced qualifying values. (Dir. Ex. 37) An October 15, 1998, spirometry also produced qualifying values and this test was found to be valid by Dr. Burki in a November 7, 1998, consultative review. (Dir. Exs. 8, 28)

A pulmonary function study performed on July 26, 1999, produced qualifying values. (Dir. Ex. 28) However, in an April 13, 2000, consultative review, Dr. Burki invalidated this test because

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[10] Forced expiratory volume in one second

[11] Forced vital capacity

[12] Maximum voluntary ventilation

the equipment did not meet the relevant specifications as demonstrated by slow paper speed. (Dir Ex. 29)

A July 10, 2001, spirometry produced qualifying values. (Dir. Ex. 39) In his report of September 24, 2001, Dr. Broudy questioned the validity of this test stating that the "tracings . . . suggest that exhalation was not as forceful as it should be. I believe sub-optimal effort accounts for the results that are lower than . . . [those] obtained by me on August 14, 2001." (Er. Ex. 2) Dr. Broudy also noted that the test "may be valid . . . because there [was] repeatability between the test trials." (Er. Ex. 2)

A pulmonary function study conducted on August 14, 2001, produced qualifying values. (Er. Ex. 1) Dr. Broudy, who observed the test, noted in his medical report that the Claimant's effort was satisfactory. (Er. Ex. 1)

As discussed above, the July 26, 1999, test was invalidated by Dr. Burki and Dr. Broudy called into question the validity of the July 10, 2001, test. (Dir. Ex. 29, 39) In assessing the reliability of a pulmonary function study, an administrative law judge may accord greater weight to the opinion of a physician who reviewed the tracings. Street v. Consolidation Coal Co., 7 BLR 1-65 (1984). Little or no weight may be accorded to a pulmonary function study were the Claimant exhibited "poor" cooperation or comprehension. Houchin v. Old Ben Coal Co., 6 BLR 1-1141 (1984); Runco v. Director, OWCP, 6 BLR 1-945 (1984); Justice v. Jewell Ridge Coal Co., 3 BLR 1-547 (1981). However, more weight may be given to the observations of technicians who administered the studies than to physicians who reviewed the tracings. Revnack v. Director, OWCP, 7 BLR 1-771 (1985). Indeed, if the judge credits a consultant's opinion over one who actually observed the test, a rationale must be provided. Brinkley v. Peabody Coal Co., 14 BLR 1-147 (1990). Further, a consulting physician who merely places a checkmark in a box indicating "poor or unacceptable technique," without explanation, has not provided sufficient evidence to support his or her rejection of the study. Gabino v. Director, OWCP, 6 BLR 1-134 (1983).

I find the opinion of Dr. Burki regarding the July 26, 1999, pulmonary function study to be entitled to great weight. Dr. Burki is a highly qualified physician, being a specialist in Internal Medicine and Pulmonary Disease. Furthermore, his rationale for invalidating this test, that the paper speed was to slow, is an objective rather than subjective reason. As such, I find the July 26, 1999, spirometry to be invalid. I find the opinion of Dr. Broudy regarding the July 10, 2001, pulmonary function study to be

entitled to less weight. While he questions the Claimant's effort, he also states that the test may be valid. These two contradicting statements make his opinion regarding this test equivocal and, therefore, entitled to little weight. As no other physician of record has questioned the validity of the July 10, 2001, test, I find it to be valid.

In reviewing the spirometry results of record, I assign the greatest probative weight to the more recent tests of record. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. Coleman v. Ramey Coal Co., 18 BLR 1-9 (1993). The four most recent pulmonary function studies conducted between 1995 and 2001 that I have determined to be valid, all produced qualifying values. As such, the Claimant has established the existence of a totally disabling pulmonary or respiratory impairment pursuant to §718.204(b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO2 to pO2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from the Claimant's lung alveoli to his blood. § 718.204(b)(2)(ii) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following Section 718 of the regulations. The blood gas studies conducted on September 21, 1992, December 19, 1994, October 15, 1998, July 26, 1999, and August 14, 2001, all failed to produced qualifying values under the regulatory standards for disability. (Dir. Ex. 5, 9) Therefore, I find that the blood gas study evidence of record fails to establish total disability under subsection (b)(2)(ii).

Total disability under Section 718.204(b)(2)(iii) is inapplicable because the Claimant failed to present evidence of cor pulmonale with right-sided congestive heart failure.

Finally, the Claimant may establish total disability under Section 718.204(b)(2)(iv). Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii) or (b)(iii), Section 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable gainful work. The medical opinion evidence of record supports a finding of total disability.

In reviewing the medical narrative evidence of record, for the

reasons stated above, I again assign greater weight to the most recent opinions. Drs. Westerfield, DeGuzman, Sundaram, Rasmussen, Burki, and Dr. Broudy, in his 2001 reports, all found the Claimant to be totally disabled and/or unable to perform his last coal mine employment. Dr. Fritzhand is the only physician of record to opine that the Claimant is not totally disabled. As his report was rendered in 1994, I find it entitled to less weight due to its age. Furthermore, I find Dr. Fritzhand's opinion outweighed by the medical reports and objective laboratory results of record. As both the medical narrative evidence of record and the pulmonary function study results both demonstrate that the Claimant suffers from a totally disabling respiratory and/or pulmonary impairment, I find that total disability has been established pursuant to §§718.204(b)(2)(i) and (iv).

Total Disability Due to Pneumoconiosis:

The Claimant must next establish that his totally disabling respiratory and/or pulmonary impairment is due to pneumoconiosis pursuant to §718.204(c)(1). Total disability due to pneumoconiosis requires that pneumoconiosis, as defined in §718.201, be a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. Substantially contributing cause is defined as having a "material adverse effect on the miner's respiratory or pulmonary condition" or as "materially worsen[ing] a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment." §718.204(c)(1)(i) and (ii). Absent a showing of cor pulmonale or that one of the presumptions of §718.305 are satisfied, it is not enough that a miner suffers from a disabling pulmonary or respiratory condition to establish that this condition was due to pneumoconiosis. See §718.204(c)(2). Total disability due to pneumoconiosis must be demonstrated by documented and reasoned medical reports. Id. In interpreting this requirement, the Sixth Circuit has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. Peabody Coal Co. v. Smith, 12 F.3d 504, 506-507 (6th Cir. 1997). Recently, in Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk], 264 F.3d 602 (6th Cir. 2001), the Sixth Circuit re-examined the "contributing cause" standard expressed in the amended Regulation provisions at 20 C.F.R. § 718.204(c). The court found that, under the amended regulatory provisions, the mere fact that a Claimant's non-coal dust related respiratory disease would have left him totally disabled even without exposure to coal dust, did not preclude entitlement to benefits. The court held that Claimant "may nonetheless possess a compensable injury if his pneumoconiosis 'materially worsens' this condition." Id.

As neither cor pulmonale nor one of the presumptions of §718.305 has been established, the Claimant may only succeed in this claim for benefits if he can establish through medical narrative evidence that his total disability was caused by pneumoconiosis. Drs. DeGuzman, Sundaram, and Rasmussen each diagnosed the Claimant as suffering from pneumoconiosis and opined that the Claimant's total disability was due to that disease. Dr. Rasmussen specifically identified three factors contributing to or potentially contributing to the Claimant's impairment. Of those three factors, Dr. Rasmussen noted that coal dust exposure was a contributing factor to the Claimant's impairment. Dr. Westerfield also diagnosed pneumoconiosis, but found that the Claimant's impairment was caused by COPD. The etiology of the Claimant's COPD was cigarette smoking. Dr. Burki made a diagnosis of pneumoconiosis and total disability. However, he opined that while dust exposure may have possibly contributed to pulmonary impairment, the likelihood of that contribution was minimal. Dr. Broudy did not diagnosis pneumoconiosis and found that the Claimant's impairment was solely due to cigarette smoking. Dr. Fritzhand found no evidence of pneumoconiosis or impairment.

Reviewing the medical opinions of record, I assign the greatest probative weight to Drs. Rasmussen, DeGuzman, and Sundaram, and find that total disability due to pneumoconiosis has been established. I find the opinions of these physicians to be well-reasoned and well-documented on this issue. Drs. DeGuzman and Sundaram served as the treating physicians, and because I have found their opinions to be credible and reliable, their findings are entitled to great probative weight. I note that Drs. DeGuzman, Sundaram, and Rasmussen all utilized objective laboratory testing, physical examination, symptomatology, and social, medical, and occupational histories in reaching their conclusions. Drs. Sundaram and Rasmussen are highly-qualified physicians being board-certified Internal Medicine specialists. While all these physicians based their opinions, in part, on positive x-rays where I have found the x-ray evidence to be negative, I find that this does not detract from their opinions on total disability causation because x-ray evidence is not indicative of total disability etiology. Furthermore, while Dr. Rasmussen also relied, in part, upon a pulmonary function study later found to be invalid by Dr. Burki, I find that Dr. Rasmussen's opinion is still reliable, credible, and well-reasoned because he relied on significant additional factors and data in reaching his conclusions. It is error to discredit a physician's report solely because of his or her reliance upon non-qualifying testing where the physician also relied upon a physical examination, work and medical histories, and symptomatology of the miner. Baize v. Director, OWCP, 6 BLR 1-730 (1984); Wike v. Bethlehem Mines Corp., 7 BLR 1-593 (1984); Coen v.

Director, OWCP, 7 BLR 1-30 (1984); Sabett v. Director, OWCP, 7 BLR 1-299 (1984). See also Cornett v. Benham Coal, Inc., 227 F.3d 569 (6th Cir. 2000).

I assign less probative weight to the opinions of Drs. Broudy and Fritzhand. Neither physician opined that the Claimant suffered from pneumoconiosis and I have determined that the Claimant has established that he does have that disease. In those cases where the administrative law judge finds that pneumoconiosis has been established those medical opinions wherein the physicians do not diagnose the miner as suffering from pneumoconiosis may be accorded little probative value. Hobbs v. Clinchfield Coal Co., 45 F.3d 819 (4th Cir. 1995); see also Toler v. Eastern Assoc. Coal Co., 43 F.3d 109 (4th Cir. 1995); Scott v. Mason Coal Co., ___ F.3d ___, Case No. 99-1495 (4th Cir. May 2, 2002). Furthermore, I find the opinion of Dr. Fritzhand entitled to less weight given the age of his findings.

I find the opinion of Dr. Burki on the issue of total disability causation to be entitled to less weight because I find that it is not well-reasoned and it is vague and equivocal. Dr. Burki opined that "given the minimal evidence of pneumoconiosis on radiographs, the likely contribution of coal dust exposure to the pulmonary function abnormality, while possible, is likely to be minimal." As discussed above, x-ray evidence is not indicative of total disability etiology. As Dr. Burki bases his conclusions on total disability causation on x-ray evidence, I find it entitled to less weight. Furthermore, I note that Dr. Burki does not entirely discount the effect of the coal dust exposure on the Claimant's pulmonary impairment. He merely states that the effect of such is "likely to be minimal." I find such a statement to be vague and equivocal. Additionally, I find Dr. Burki's findings entitled to less weight because he did not personally examine the Claimant.

While Dr. Westerfield opined that the Claimant's impairment is due to cigarette smoking induced COPD, I find his opinion outweighed by those of Drs. DeGuzman, Rasmussen, and Sundaram. The evidentiary standard for entitlement of benefits is a preponderance of the evidence standard. As discussed above, I have found significant flaws in the opinions of Drs. Burki, Fritzhand, and Broudy, which results in the opinions of those physicians being entitled to less weight on the issue of total disability causation. As between Drs. Rasmussen, Sundaram, DeGuzman, and Westerfield, I find each of their opinions to be well-reasoned, well-documented and entitled to probative weight. The opinions of Drs. Rasmussen, Sundaram and DeGuzman, who each found that the Claimant's totally disabling respiratory/ pulmonary impairment was due, at least in part, to pneumoconiosis constitutes a preponderance of the evidence

outweighing the opinion of Dr. Westerfield. Accordingly, I find that total disability due to pneumoconiosis has been established pursuant to §718.204(c)(1).

Entitlement:

Because the Claimant has proven the existence of pneumoconiosis, he has established a material change in condition since the prior denial of benefits. Furthermore, the Claimant has now satisfied all elements of entitlement and is therefore entitled to benefits under the Act.

Date of Entitlement:

Generally, the date of commencement of benefits is determined by the date of onset of total disability due to pneumoconiosis. §§725.503, 727.302, 727.303. Rochester & Pittsburgh Coal Company v. Krecota, 868 F.2d 600 (3rd Cir. 1989) If medical evidence does not establish the date on which the Claimant became totally disabled due to pneumoconiosis, then the Claimant is entitled to benefits as of his filing date, unless there is medical evidence which, if credited, indicates that the Claimant was not totally disabled at some point subsequent to his filing date. Lykins v. Director, OWCP, 12 BLR 1-181 (1989). In cases of re-filed claims pursuant to §725.309, once a "material change in condition" is demonstrated, the subsequent claim is to be considered a new and viable claim. Therefore, the filing date of the subsequent claim determines which substantive regulations apply as well as the earliest date from which benefits may be awarded if the miner is found to be so entitled. Spese v. Peabody Coal Co., 11 BLR 1-174, 1-176 (1988), *dismissed with prejudice*, Case No. 88-3309 (7th Cir. Feb. 12, 1989)(unpub.). See also Peabody Coal Co. v. Spese, 117 F.3d 1001 (7th Cir. 1997)(en banc) (the earliest date of onset in a multiple claim under § 725.309 is the date on which that claim is filed; the claim does not merge with earlier claims filed by the miner).

The amended regulations also provide that the filing date of the subsequent claim constitutes the earliest date from which benefits are payable as § 725.309(d)(5) provides that "[i]n any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final." § 725.309(d)(5)(2000).

The record in this case does not contain any medical evidence establishing exactly when the Claimant became totally disabled. Therefore, payment of benefits is established as of September 1998, the month and year in which the Claimant filed this claim for

benefits.

Attorney's Fees:

No award of attorney's fees for service to the Claimant is made herein because no application has been received from counsel. A period of 30 days is hereby allowed for the Claimant's counsel to submit an application. Bankes v. Director, 8 BLR 2-1 (1985). The application must conform to 20 CFR § 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including the Claimant and Solicitor as counsel for the Director. Parties so served shall have 10 days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge the Claimant any fee in the absence of the approval of such application.

ORDER

IT IS THEREFORE ORDERED that, the Employer, Rifle Coal Co. Inc., shall pay to the Claimant, PAUL PENNINGTON, all benefits to which he is entitled under the Act commencing as of September, 1998. IT IS FURTHER ORDERED that the Employer shall pay the Claimant's attorney, Cynthia Mulliken, Esquire, fees and expenses to be established in a supplemental decision and order.

A

DANIEL J. ROKETENETZ
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this decision, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.